Standards and Methods Used to
Assure High Quality of Care

1. An ambulatory care review procedure will be initiated using established practice standards as criteria for reviewing physician's claims for the purpose of allowing physicians to compare their own practice with standards accepted by their peers as representing good practice. Although the criteria are too lengthy to be printed herein, a complete copy of the criteria for practice standards is available from the Montana Foundation for Medical Care, 1400 eleventh Avenue, Helena, Montana 59601. The criteria will be used as the basis to determine whether review is necessary but will not be used for denial of adjustment of claims. Non-drug, non-institutional claims may be adjusted or denied where review and consultation with the attending physician indicates that the claim is inappropriate or outside of the bounds of good practice. The step-by-step review process is as follows:

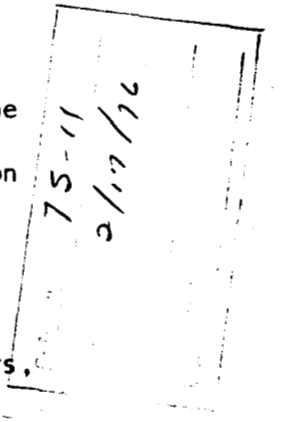
(a) All non-drug, non-institutional claims received by the Department' computer system will be reviewed against the selection criteria specified by the Montana Foundation for Medical Care. Services which do not fall outside the criteria will be processed and paid in the normal manner.

(b) All claims for services which are selected out by reason of failure to meet the selection criteria, will be sent to the office of Montana Foundation for Medical Care, with a printed copy of the patient's treatment history produced from the department's computer system. The attending physician will be notified on his weekly payment voucher that the claim has been referred to ambulatory care review.

(c) Foundation personnel will send a copy of the claim and the patient's history to the appropriate review physician. The reviewing physician will approve or deny the claim as billed or request more information from the attending physician through the central office or refer the claim to the Peer Review Regional Sub-Committee for consideration. The Peer Review Regional Sub-Committees will meet regularly to review claims referred by the individual physicians and have the power to approve, reduce or deny payment of a claim. Communication with the attending physician regarding the results of the Peer Review and requests for additional information will be made by telephone from the Foundation Office.

(d) Review action will be coded on the original claim at the Foundation, and the claim returned to the Department for final processing, and subsequent payment or notice of denial to the attending physician.

(e) The attending physician will be provided with means to appeal an adverse decision. The attending physician may contest the decision at the Peer Review Regional Sub-Committee level. If the attending physician is dissatisfied with their decision, appeal can be made to the full Peer Review Committee. Those members who have heard the appeal at the Regional level will be excluded from participation in the adjudication of the appeal by the full Peer Review Committee. If the attending physician is dissatisfied with the judgment of the full Peer Review Committee, an appeal can be taken to the Foundation Board of Directors, whose findings represent the final administrative decision.



2. The institutional review component will incorporate pre-admission screening of all elective admissions for medical necessity, certification

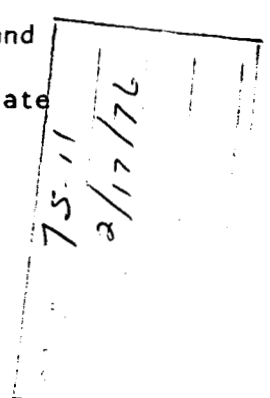
within 48 hours of urgent and emergent admissions, concurrent review during hospitalization to determine appropriate length of stay, discharge planning to facilitate patient transfer to an appropriate level of care when medically indicated, collection of data in order to effectively measure results and support management in quality control of the program using established practice standards as criteria to review the above functions. Although the criteria are too lengthy to be printed herein, a complete copy of the criteria for practice standards is available from the Montana Foundation for Medical Care, 1400 eleventh Avenue, Helena, Montana 59601.

3. One aspect of institutional review will cover initial certification for elective admissions (any admission considered by the attending physician to be non-emergent). The step-by-step review process is as follows:

(a) When the attending physician schedules a patient for hospital admission, he will either complete a certification request form and mail it to the program coordinator or supply the necessary information by telephone to the program coordinator who will then complete the certification request form. The information required shall include enumeration of the patient's problems which necessitate hospital admission, including the admitting diagnosis and the anticipated treatment.

(b) The program coordinator will process these forms daily, and according to the pre-established criteria, will assign the appropriate number of days.

(c) The program coordinator will send a copy of the approved certification request to the physician and hospital within two (2) working days of the date of the request.



(d) In the event there is difficulty in determining the length of stay from the information available, assistance of the assigned physician advisor shall be obtained.

(e) It will be the function of the physician advisor, or his assigned alternate, to assist the program coordinator in making all decisions requiring professional judgment.

(f) The physician advisor may deny certification if after reasonable evaluation of the information submitted, he determines in his opinion, that hospital confinement is not medically necessary. If such a determination is made, the hospital and physician will be notified by telephone within two (2) working days of the date of request, with confirmation in writing to follow. The notification to the physician will explain the procedures by which he may appeal the decision. The hospital will notify the program coordinator no later than the first working day after the patient is admitted and the approved number of days will be recorded on the patient's chart.

(g) Foundation personnel must rely on the hospital for verification of Medicaid eligibility. In those cases where eligibility has not been established, but is suspected or has been applied for, the certification process will be applied.

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4. One aspect of the institutional review will cover initial certification of emergency admissions. The step-by-step review process is as follows:

(a) At the time of admission or within one(1) working day thereafter, the attending physician will either complete a certification request form or supply the necessary information to the program coordinator for

completion of the form.

(b) The program coordinator will process the forms on a regular basis and will follow the same certification and distribution procedures specified for elective admissions, above.

(c) Emergency admissions will be subject to Foundation review during confinement and at the time of discharge as to medical necessity.

5 Institutional review shall be made for extensions of initial certifications. The step-by-step review process is as follows:

(a) The attending physician will be notified by the program coordinator of the initially certified date of discharge not less than two (2) days prior to such date.

(b) If the attending physician feels that an extension of stay is medically necessary, it will be his responsibility to obtain such certification by submitting an extension request form to the program coordinator at a reasonable time (not less than one (1) full working day) in advance to the initially certified date of discharge.

(c) The program coordinator may either grant a specific number of days extension, or seek review and decision by the designated physician advisor. In all cases, the responsible attending physician may request immediate review by the designated appeal's committee within his hospital.

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(d) When an extension is granted, the program coordinator will notify all parties concerned. Such notification may be made by telephone and copies of the approved extension request form will be given to the hospital and physician.

(e) Under circumstances not permitting a request in writing, the physician may request an extension by telephoning the program coordinator or, if unavailable, the central Foundation office. In this case, the

physician must submit an extension request form to the program coordinator no later than the first working day following.

(f) If a previously anticipated weekend or holiday discharge is cancelled because of a change in a patient's condition which necessitates further hospitalization, the physician will submit an extension request form to the program coordinator on the first working day following.

(g) If an extension request is denied and the physician appeals the decision, the Medicaid program will be responsible for hospital benefits up to and including the date on which the decision is made at the first level of appeal if the appeal decision is made against the attending physician.

6 Under the institutional review procedure, an attending physician may seek immediate review of an adverse decision by requesting immediate review by the designated appeals committee within the hospital. If the attending physician is dissatisfied with their decision, appeal can be made to the Peer Review Regional Sub-Committee. Should the attending physician wish further review appeal can be made to the full Peer Review Committee. Those members who have heard the appeal at the regional level will be excluded from participation in the adjudication of the appeal by the full Peer Review Committee. If the attending physician is dissatisfied with the judgment of the full Peer Review Committee, an appeal can be taken to the Foundation Board of Directors, whose findings represent the final administrative decision.

7. The program coordinator in the institutional review procedure is responsible for certain duties including the following:

(a) The program coordinator is responsible for regular monitoring

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of appropriate Medicaid patient records in each hospital.

(b) The program coordinator secures diagnosis in emergency cases to determine length of stay.

(c) The program coordinator notes changes in diagnosis and recertifies where appropriate length of stay is indicated by changes of diagnosis. This recertification may not be less than the number that the patient has already been hospitalized under the original diagnosis. In those cases in which the program coordinator observes a revised diagnosis which justifies an initial length of stay less than the number for which the patient has already been hospitalized, the responsible physician must obtain an extension, or the Medicaid program will cease to be liable if the patient is not discharged.

(d) In each location where the discharge planning function is operative, the Montana Foundation for Medical Care will identify and catalog health care resources available to Medicaid beneficiaries. This information will be available to each program coordinator.

(e) The program coordinator will identify, as soon after admission as possible, those patients who may be released for other types of care after discharge.

(f) The program coordinator, in cooperation with the attending physician, hospital staff, patient, and patient's family, defines what future needs must be met.

(g) After needs have been defined, the program coordinator may suggest alternatives, and assist the appropriate hospital and State of Montana personnel in the arrangement for access to the appropriate care facilities or services.

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8. Institutional and ambulatory review procedures may vary in sparsely-populated areas. For information on procedures in specific areas, contact the Montana Foundation for Medical Care, 1400 Eleventh Avenue, Helena, Montana, 59601.

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